Provider Relations

Annual CAP Report

2027 Contracting

Kansas

Introduction

Blue Cross and Blue Shield of Kansas (BCBSKS) is the health plan that Kansans trust. Much of that status can be attributed to the high-quality care delivered by our network providers. This document outlines our 2027 Competitive Allowance Program (CAP) offer and includes the specifics of our Quality-Based Reimbursement Program (QBRP), which has been designed to reward your efforts in maintaining high-quality standards.

BCBSKS continues to offer contracting providers top-notch services, including provider relations representatives and provider network enrollment. Our provider relations representatives conduct in-person visits, trainings and workshops. We are also available to conduct these activities virtually based on the provider's preference. Thank you for your versatility in working with our provider relations team to meet your needs. We also want to extend our appreciation to you and your staff for caring for our members.

If you need clarification or additional information, contact your provider relations representative or provider network enrollment.

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Introduction

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Benefit of Blue

As Kansas' largest not-for-profit health plan, BCBSKS is dedicated to supporting participating providers through competitive reimbursement opportunities, quality initiatives, robust self-service tools and local support. The following highlights showcase the value of partnering with BCBSKS.

BCBSKS Advantage	What It Means for You
Trusted Health Plan	BCBSKS is a top-rated health plan for member satisfaction and serves **984,246 members** across all lines of business (excluding Healthy Blue) as of May 31, 2026. BCBSKS invests **86.26% of every premium dollar in member care**.
Quality and Value Programs	BCBSKS maintains **100% URAC accreditation** in Health Plan, Case Management, Health Equity and Disease Management and continues to support value-based care initiatives through **Patient-Centered Medical Home (PCMH)** arrangements and the **Quality-Based Reimbursement Program (QBRP)**.
Strong Provider Network and Reimbursement Opportunities	BCBSKS contracts with approximately **99% of eligible physicians and 96% of eligible professional providers in the service area**. Participating CAP providers may receive reimbursement of up to **100% of the Maximum Allowable Payment (MAP)** - subject to member benefits - and have opportunities to earn additional revenue through QBRP incentives.
Claims, Payment and Provider Support	BCBSKS provides **direct claim payment**, electronic remittance and payment capabilities, **detailed claims-payment information** for providers and members, Provider Network Enrollment support and **dedicated local field staff** to help resolve operational issues.
Tools, Resources and Practice Growth	Providers benefit from **online self-service tools** through bcbsks.com, Availity and the provider portal, including claims, eligibility, remittance, enrollment, data attestation, QBRP tracking and secure correspondence. Additional resources include training modules, **workshops**, newsletters, manuals, policy memos and medical policies/guidelines. Provider participation also increases visibility through **online directories**, employer groups and referral networks, helping attract new patients.

Note: 2027, for the majority of our business, non-contracting providers' services will be paid direct to the member at a charge up to 80% of the MAP - i.e. there is a 20% penalty for members receiving services from a non-contracting provider - subject to member benefits. In addition, assignment of benefits to non-contracting providers is not allowed. Non-contracting providers do not qualify for QBRP incentives.

2027 Reimbursement and Policy Memo Changes

A summary of the policy memo changes is enclosed for your review. Highlights of changes are noted in red.

Highlights of the 2027 reimbursement are noted below. We have made changes to the Quality-Based Reimbursement Program (QBRP) which started in 2012 to encourage higher quality care and better control of healthcare costs. Our reimbursement program for 2027 will continue to create opportunities for providers to earn incentives by meeting the criteria as outlined in the 2027 QBRP as described on pages 6-12.

Please note that along with base rate changes, additional reimbursement is available through the QBRP program where noted.

Increasing	No Change	Decreasing
Anesthesia conversion factor at $78.36	Primary care and behavioral health providers in qualifying rural counties with a population of 13,000 or less will continue to receive a 5 percent add-on to the MAP on all eligible services. See county listing on page 19	Overvalued CPT and DME codes were recalibrated downward to better align reimbursement with market benchmarks
Professional codes were increased 7.36% overall, before accounting for QBRP changes		
Previously undervalued CPT and Durable Medical Equipment (DME) codes were adjusted upward (eligible for QBRP where applicable)		
Nearly all codes recieved some level of a base rate increase to account for QBRP changes		
ABA reimbursement for non-physician services was standardized removing tiered payment levels		

Tiered Reimbursement

The allowances for professional services associated with the following specialties have been set at the identified percentages of the MAP - no percent changes for 2027.

85 Percent*	70 Percent*	50 Percent*
Advanced Practice Registered Nurses (APRNs) - not including Certified Registered Nurse Anesthetists (CRNAs)	Community Mental Health Centers	Certified Occupational Therapy Assistants (COTAs)
Chiropractors	Licensed Clinical Marriage and Family Therapists	Certified Physical Therapist Assistants (CPTAs)
Clinical Psychologists	Licensed Clinical Professional Counselors	Licensed Athletic Trainers (LATs)
Occupational Therapists	Licensed Clinical Psychotherapists	Individual Intensive Support (IIS) providers Registered Behavior Technician (RBT)
Physical Therapists	Licensed Specialist Clinical Social Workers (LSCSWs)	
Physician Assistants	Outpatient Substance Abuse Facilities	
Speech Language Pathologists	Master's Level Social Workers Licensed Marriage and Family Therapist Licensed Master Level Psychologist Licensed Master Level Social Worker Licensed Master Addiction Counselor Licensed Professional Counselor	
Licensed Dietitians/Certified Diabetic Educators	Autism Specialists (AS)	

*Amounts are rounded to the nearest $0.01 per line item. Refer to fee schedule for allowances. The following codes are not subject to tiered reimbursement: 97152, 97153, 97154, 97155, 97156, 97157, 97158, 99415, 99416, 99439, 99457, 99458, 99487, 99489, 99490.

2027 Professional Providers QBRP

The BCBSKS Quality-Based Reimbursement Program (QBRP) is designed to , improve quality, and lead to better patient care and outcomes. Contracting BCBSKS providers have an opportunity to earn additional revenue through add-ons to allowances for meeting the defined quality metrics. BCBSKS claims data is used to determine qualification for any applicable metric requiring data.

Each year, BCBSKS seeks opportunities to best align meaningful clinical metrics with incentives to drive improved outcomes.

IMPORTANT REMINDER — The 2027 QBRP program is effective for services performed Jan. 1, 2027 through Dec. 31, 2027. Since the 2027 Annual CAP Report is sent out July 31, 2026, providers have several months to prepare to meet the various QBRP metrics and qualify for incentives effective Jan. 1, 2027, in accordance with the metric review schedule (see pages 10-17). Read the requirements and metrics for the 2027 QBRP program so you are prepared to maximize the available incentives. Any subsequent pertinent information or clarification will be communicated accordingly.

Criteria for 2027

In accordance with the 2027 Policy Memo No. 1, Section 29 Reimbursement for Quality, this document describes the components of QBRP effective Jan. 1, 2027 through Dec. 31, 2027. This program applies to all BCBSKS CAP, PPO, FEP, EPO and BlueCard professional providers and services except for clinical lab - using codes on the Medicare clinical lab fee schedule, pharmacies and pharmaceuticals, dental services and as determined by BCBSKS.

This program will offer an opportunity for eligible providers to earn increased reimbursement allowances based on a two-group approach - Groups B and C. These reimbursement allowances will be in addition to the established base MAPs for 2027.

Note: Changes in CPT[1] codes added or deleted will be effective prospectively. QBRP adjustments/corrections will be effective the first of the following month, unless otherwise specified.

In order to pay incentives on the metrics in Groups B and C, we developed a doctor/patient registry. BCBSKS will review claims from the preceding 12 to 24 months and attribute patients to the applicable physicians based on the frequency of office visit encounters with a given physician. In the event multiple physicians have the same number of encounters for the same patient, the patient will be attributed to the physician with the most recent encounter.

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2027 Professional Providers QBRP

The quality-based incentives will be earned at the individual provider level unless otherwise specified. Qualification to participate in the incentives made available in the program will vary depending on provider type. An eligible provider may independently qualify for each metric, except when measured on a group basis. The QBRP metrics are multiplied individually by the MAP, then totaled with the MAP to determine the total reimbursement "QBRP MAP." BCBSKS will allow the lesser of the provider's charge or the "QBRP MAP."

In order for incentive payments to begin Jan. 1, 2027, BCBSKS will use information on file or available from outside sources to determine which incentives providers qualify for based on unique provider individual NPI numbers, billing NPI numbers or tax ID, whichever is applicable.

Note: BCBSKS built enhancements to the provider information portal to include self-service QBRP information.

All metrics will be reviewed on a semi-annual basis, and any incentives earned will be effective either **Jan. 1, 2027 or July 1, 2027**, as applicable.

BCBSKS will conduct a QBRP refresh in the first and second quarters - depending on the metric - of 2027 for an effective date of July 1, 2027 to determine if providers are continuing to meet the performance standards for the metric(s) earned for the incentive payments effective Jan. 1, 2027. If the refreshed data indicates a provider is no longer meeting the performance standards for the metric(s), then the associated QBRP incentive(s) will cease beginning July 1, 2027 for the remainder of the year. Confirmation of QBRP measures can be obtained on the provider portal. The portal will reflect effective and termination dates of all applicable QBRP measures.

QBRP Prerequisites and Groups for Providers	
QBRP Participation Prerequisites	Providers must conduct business with BCBSKS electronically Providers must submit all eligible claims electronically. Provider must be in good standing with BCBSKS to qualify for and receive QBRP. QBRP will cease if provider is no longer in good standing.
Group B	Applies to all prescribing provider types - MD; DO; DPM; OD; PA; APRN; CRNA as applicable to the measure and to all eligible/covered CPT codes - excludes Clinical Lab using codes on the Medicare clinical lab fee schedule, Pharmacy and Pharmaceuticals, Dental services, and determined by BCBSKS.
Group C	Applies to all prescribing provider types - MD; DO; DPM; OD; PA; APRN; CRNA - as applicable to the measure and only to covered E&M codes

2027 Professional Providers QBRP

Metric	%	Group	Description	Qualifying Period
Breast Cancer Screening (BCS)	1.0	B	The percentage of women 40-74 years of age - 42-74 as of the end of the measurement period - who had a mammogram anytime in the past two years. Must be greater than or equal to 75% to meet the metric, calculated at the provider group level having at least five attributed/ eligible patients for breast cancer screening. Individual providers in the group must have at least one attributed/eligible patient to receive incentive. **Note:** OB/GYN and Geriatrician providers can qualify as well.	Semi-annual
Cervical Cancer Screening (CCS)	1.5	B	The percentage of women 21-64 years of age who were screened for cervical cancer. Must be greater than or equal to 75% to meet the metric, calculated at the provider group level having at least five attributed/ eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive.	Semi-annual
Colorectal Cancer Screening (COL)	1.0	B	The percentage of adults 45-75 years of age - 46-75 as of Dec. 31 of the measurement year - who had appropriate screening for colorectal cancer. Members with multiple screenings will be counted only once as appropriately screened. Must be greater than or equal to 60% to meet the metric, calculated at the provider group level having at least five attributed/eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive.	Semi-annual
Low-Back Pain (LBP)	1.0	B	The percentage of members with a primary diagnosis of low back pain who did not have an imaging study - plain X-ray, MRI, CT scan - within 28 days of diagnosis. The percentage is reported as an inverted rate, therefore, a higher reported rate indicates appropriate treatment of low back pain - i.e. proportion for whom imaging studies did not occur. Must be greater than or equal to 90% to meet the metric, calculated at the provider group level having at least five attributed/ eligible patients. Individual providers in the group must have at least one attributed/ eligible patient to receive incentive. **Note:** The member is attributed to the provider associated with the earliest date of service for an eligible encounter with a principal diagnosis of low back pain, regardless of specialty. Although not prescribing providers, chiropractors will be eligible for this Group B measure.	Semi-annual

2027 Professional Providers QBRP

Metric	%	Group	Description	Qualifying Period
Well-Child visits (W30A) 6 or more visits in first 15 months	1.0	B	The percentage of members 0-15 months of age who had six or more well-child visits with a PCP during the first 15 months of life. Must be greater than or equal to 80% to meet the metric, calculated at the provider group level having at least 5 attributed/eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive.	Semi-annual
Well-Child visits (W30B) 2 or more visits during months 15-30	1.0	B	The percentage of members 15-30 months of age who had two or more well-child visits with a PCP between 15-30 months of life. Must be greater than or equal to 80% to meet the metric, calculated at the provider group level having at least 5 attributed/eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive.	Semi-annual
Well-Child visits (WCV) 1 or more visits for members 3-21 years of age	1.0	B	The percentage of members 3-21 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the measurement year. Must be greater than or equal to 50% to meet the metric, calculated at the provider group level having at least 5 attributed/eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive.	Semi-annual
Statin Therapy for Patients with Cardiovascular Disease (SPC)	1.0	B	The percentage of males 21-75 years of age and females 40-75 years of age during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year. Must be greater than or equal to 80% to meet the metric, calculated at the provider group level having at least five attributed eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive.	Semi-annual
Statin Therapy for Patients with Diabetes (SPD)	1.0	B	The percentage of members 40-75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one statin medication of any intensity during the measurement year. Must be greater than or equal to 65% to meet the metric, calculated at the provider group level having at least five attributed eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive.	Semi-annual

2027 Professional Providers QBRP

Metric	%	Group	Description	Qualifying Period
Eye Exams for Patients with Diabetes (EED)	1.0	B	The percentage of members 18-75 years of age as of the end of the measurement year with diabetes - type 1 or type 2 - who had an eligible screening or monitoring for diabetic retinal disease as identified by administrative data. Must be greater than or equal to 50% to meet the metric, calculated at the provider group level having at least five attributed eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive.	Semi-annual
Avoidance of Antibiotic Treatment in Members with Acute Bronchitis (AAB)	1.5	C	The percentage of members 3 months of age and older with a diagnosis of acute bronchitis/bronchiolitis who were not dispensed an antibiotic prescription. Must be greater than or equal to 50% to meet the metric, calculated at the provider group level having at least five attributed/ eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive. **Note:** The member is attributed to the provider associated with the earliest date of service for an eligible encounter with a principal diagnosis of acute bronchitis, regardless of specialty.	Semi-annual
Appropriate Testing for Members with Pharyngitis (CWP)	1.5	C	The percentage of members 3 years of age and older who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. A higher rate represents better performance - i.e. appropriate testing. Must be greater than or equal to 70% to meet the metric, calculated at the provider group level having at least five attributed/eligible patients. Individual providers in the group must have at least one attributed/ eligible patient to receive incentive. **Note:** The member is attributed to the provider associated with the earliest date of service for an eligible encounter with a principal diagnosis of pharyngitis - regardless of specialty.	Semi-annual

2027 Professional Providers QBRP

Metric	%	Group	Description	Qualifying Period
Appropriate Treatment for Members with Upper Respiratory Infection (URI)	1.5	C	The percentage of members 3 months of age and older who were given a diagnosis of upper respiratory infection and were not dispensed an antibiotic prescription. Must be greater than or equal to 80% to meet the metric, calculated at the provider group level having at least five attributed/ eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive. **Note:** The member is attributed to the provider associated with the earliest date of service for an eligible encounter with a principal diagnosis of URI, regardless of specialty.	Semi-annual
Follow-up After Hospitalization for Mental Illness (FUH)	0.5	C	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of a selected mental illness or intentional self-harm diagnosis and who had a follow-up visit with a mental health provider within 7 days after discharge. Must be greater than or equal to 70% to meet the metric, calculated at the provider group level having at least five attributed eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive. **Note:** The member is attributed to the provider associated with the earliest date of service of an eligible encounter with a principal diagnosis of mental illness or intentional self-harm, regardless of the specialty.	Semi-annual

2027 Professional Providers QBRP

QBRP Changes for 2027		
Metric	**Change**	**Reason**
Electronic Self-Service (ES3)	Sunset incentive	Incentive changes to align with future value-based strategy
Provider Information Portal (PRT)	Sunset incentive	Incentive changes to align with future value-based strategy
Electronic Provider Message Board (EPM)	Sunset incentive	Incentive changes to align with future value-based strategy
Certified Community Behavioral Health Clinic (CCBHC)	Sunset incentive	Incentive changes to align with future value-based strategy
CPT II Codes (CAT2)	Sunset incentive	Incentive changes to align with future value-based strategy
ICD-10 SDoH Codes-ZZZ	Sunset incentive	Incentive changes to align with future value-based strategy
HIE HL7 V2 (ADT) Demographic, admissions, discharges, transfers	Sunset incentive	Incentive changes to align with future value-based strategy
HIE HL7 2 (OPN via MDM) Progress notes	Sunset incentive	Incentive changes to align with future value-based strategy
HIE HL7 (ABS via ADT) Vitals, Diagnosis, Procedure coding	Sunset incentive	Incentive changes to align with future value-based strategy
HIE HL7 V2 (LAB via ORU) Lab Reporting	Sunset incentive	Incentive changes to align with future value-based strategy
HIE HL7 V2 (MED via RDE) Medication records	Sunset incentive	Incentive changes to align with future value-based strategy
CCD complete/all data (KCCD)	Sunset incentive	Incentive changes to align with future value-based strategy
Generic Utilization Rate (GUR)	Sunset incentive	Incentive changes to align with future value-based strategy
Access Formulary Electronically (EEX)	Sunset incentive	Incentive changes to align with future value-based strategy
Registry Data (REG)	Sunset incentive	Incentive changes to align with future value-based strategy
Anesthesia Performed in a Health System with a Level 1 Trauma Center (ATC)	Sunset incentive	Incentive changes to align with future value-based strategy

Rural Access Counties

The following is a list of counties with a population of 13,000 or less that qualify for a Rural Access incentive. The 5% rural access payment is separate and distinct from QBRP; however, the same QBRP procedure code exclusions apply to the rural access incentive. (Source: U.S. County 2025 Estimated Census). **Note:** Changes will be effective the first of the following month, unless otherwise specified.

County	Population
Allen	12,302
Anderson	8,018
Barber	4,083
Brown	9,104
Chase	2,572
Chautauqua	3,321
Cheyenne	2,604
Clark	1,900
Clay	7,990
Cloud	8,833
Coffey	8,467
Comanche	1,673
Decatur	2,716
Doniphan	7,594
Edwards	2,640
Elk	2,458
Ellsworth	6,257
Gove	2,631
Graham	2,371
Grant	7,028
Gray	5,652
Greeley	1,182
Greenwood	5,826
Hamilton	2,500
Harper	5,370
Haskell	3,599
Hodgeman	1,619
Jewell	2,830
Kearny	3,888
Kingman	7,029
Kiowa	2,432
Lane	1,508
Lincoln	2,861
Linn	9,950
Logan	2,661

County	Population
Marion	11,634
Marshall	9,852
Meade	3,852
Mitchell	5,590
Morris	5,348
Morton	2,470
Nemaha	10,054
Ness	2,617
Norton	5,288
Osborne	3,285
Ottawa	5,744
Pawnee	5,991
Phillips	4,728
Pratt	9,117
Rawlins	2,431
Republic	4,640
Rice	9,266
Rooks	4,646
Rush	2,845
Russell	6,581
Scott	4,815
Sheridan	2,427
Sherman	5,763
Smith	3,566
Stafford	4,005
Stanton	1,986
Stevens	4,984
Thomas	7,725
Trego	2,740
Wabaunsee	7,018
Wallace	1,441
Washington	5,533
Wichita	2,031
Wilson	8,299
Woodson	3,118

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